



# Strategic Planning FY 2020-2022

Impacting Social Determinants of Health

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February 27, 2019



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# Impact 2020 Recap



## Status and Results

- Deliver High Quality Care
- Grow to Serve and Compete
- Foster Fiscal Stewardship
- Invest in Resources
- Leverage Valuable Assets
- **Impact Social Determinants**
- Advocate for patients



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# Impact 2020

## Progress and Updates-Social Determinants of Health

Name	Status
Ensure continued access for uninsured patients	<ul style="list-style-type: none"><li>• Director of Carelink hired 11/18</li><li>• Monthly meetings with joint agenda settings established</li><li>• Carelink membership stable at 31,500</li><li>• # of Carelink members in Care Coordination 326</li><li>• Understanding admission reasons, ambulatory visits to refine care coordination approach</li></ul>
CCDPH data to plan intervention to improve population health	In Progress



# Impact 2020

## Progress and Updates-Social Determinants of Health

Name	Status
Partner with other organizations to impact social determinants of health	<ul style="list-style-type: none"><li>• Food as Medicine <b>Greater Chicago Food Depository</b> food trucks at 13 sites</li><li>• Contract in process for nutritional support for at-risk CCH patients and CountyCare members with <b>Independent Living Systems</b></li><li>• Partnership established with <b>Black Oaks</b>, planning for 2019 underway</li><li>• Completed housing 33 units for <b>Housing Forward</b>, 30 for <b>Illinois Housing Development Authority (IHDA)</b></li><li>• Training for care coordination for Coordinated Entry System and assessments</li><li>• Securing 56 vouchers for <b>Housing Authority for Cook County (HACC)</b></li><li>• Outreach started on <b>Flexible Housing Pool</b> initiative</li></ul>
Develop Care Coordination	Developed, 200 care coordination team members in multiple sites



# Additional Activities Linked to Social Determinants

Focus Area	Activities	Results
Linkages to Mental Health (MH)/Substance Use Disorder (SUD) Services	<ul style="list-style-type: none"><li>Specialized discharge planning for those with medical complications of Opioid Use Disorder (OUD)</li><li>Access to outpatient services via Behavioral Health Access Line (BHAL)</li><li>Warm hand-offs for those in pretrial area at 26<sup>th</sup> and California with MH/SUD</li></ul>	<ul style="list-style-type: none"><li>60 patients per month</li><li>500 to 600 BHAL referrals per month to ambulatory providers</li><li>Approximately 80 referrals per month to MH and SUD providers</li></ul>
Access to care	<ul style="list-style-type: none"><li>Additional support for Patient Support Center through Chicago Lighthouse</li></ul>	<ul style="list-style-type: none"><li>277,279 primary and specialty care appointments were made in 2018. (30,011 Chicago Lighthouse)</li><li>Initiation of concierge services for patients</li></ul>
Social Support	<ul style="list-style-type: none"><li>Utility Assistance</li><li>Expansion of Community Health Worker activities of linkages to community based organizations</li></ul>	<ul style="list-style-type: none"><li>\$180,000 in grants, average grant size \$250 to \$500.</li></ul>

# Additional Activities Underway

Focus Area	Activities	Results
Income/Economic Support	<ul style="list-style-type: none"><li>Legal Aid Foundation support to resolve Health Harming Needs<ul style="list-style-type: none"><li>Access to public benefits</li><li>Application for SSI and SSDI</li></ul></li></ul>	<p>2018 Referrals 256 Public Benefits 44 Housing 36 Family Law 80 ADAPT 22 Disability Cases (SSI/SSDI)</p>
Transit	<ul style="list-style-type: none"><li>Rides for discharged patients, ED patients, ACHN and methadone</li></ul>	<p>110,000 rides since 9/17 95% on time arrival 27.4 minutes for on-demand rides 8821 bus passes for methadone treatment</p>

# Social Determinants

## Facilitators

- A funding stream to enable this work this includes system resources as well as grant funds
- Health System willingness to engage for non-traditional service/support
- Staff willing to tackle the complexities associated with this work
- Willing external and internal partners

# Health Risk Screening



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# Health Risk Screening

## Identification

### Screening for Social Determinants of Health

- ED, Inpatient Units, Ambulatory Centers, Bond Court

Referrals from staff, physicians, CountyCare

Data review -- claims, utilization information

## Results

- 17,093 CountyCare members were screened during 2018

# Health Risk Screening

## Self-Reported Data

Question	Potential Risk	Question	Potential Risk Factor
Last PCP visit >1 yr	(5%)	Abuse history	(3%)
Lack of transportation for medical appts	(20%)	Afraid of family member	(.6%)
Problems obtaining or paying for meds	<b>(9%)</b>	No one to help you for a few days	<b>(26%)</b>
Overall health	<b>Fair (22.6)</b> <b>Poor (8.6%)</b>	Need help getting food	<b>(18%)</b>
Presence of MH condition	<b>(17.1%)</b>	Help with housing	<b>(10.9%)</b>
Presence of SUD	<b>(2.9%)</b>	Help with utilities	<b>(15.3%)</b>
Unstable Living Situation	<b>(2.0%)</b>	Help with clothing	<b>(12.1%)</b>

# Health Risk Screening

## Frequency of Risk Indicators

	1-3 Indictors %	4-6 Indicators %	7 or more Indicators %	Population Size
Chronic MH	43.3 %	39.7%	16.8%	2,446
Chronic SUD	26.4%	43.0%	30.4%	702
MH/SUD	16.0%	40.8%	43.0%	411
Total Population	80.4%	16.0%	3.5%	17,093



# FY2020-2022

## Opportunities



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# Impact Social Determinants/Advocate for Patients

## FY2020-2022 Strategic Planning Recommendations

### 2018 Opportunities

- External partnerships are only partially defined; not clear how well they work/support the patients or members
- Engagement of physicians and medical home team members regarding CCH capabilities
- Being able to evaluate what really works for whom



# Impact Social Determinants/Advocate for Patients

## FY2020-2022 Strategic Planning Recommendations

### Integrated Care Short-Term Plans

- Meet or exceed targets for all funded projects related to housing, opioid abuse, linkages to treatment for SMI
- Secure ongoing funding for MH/SUD activities when grant funding expires e.g. recovery coaches, AOT Assisted Outpatient Treatment (AOT) program, etc.
- Catalog existing activities regarding tobacco cessation, nutritional support, exercise and risk reduction for scalability and ease of referrals
- Identify top 3 social/community needs of CCH supported patients and identify strategy(ies) to meet needs
- Partner with CCDPH on one mutual project (housing for children at risk)
- Develop an understanding of patient approach and related successful interventions
- Develop and present a housing model for CCH patients

# Impact Social Determinants/Advocate for Patients

## FY2020-2022 Strategic Planning Recommendations

### Organizing for Impact and Sustainability

- Create a coordinating committee -- success will depend on cross-department collaboration and coordination
- Identify working definitions for social determinants of health, which ones may be in the purview of CCH departments and strategies for others that may have significant impact
  - Complete gap analysis and provide recommendations
  - Document resource requirements, training etc.
  - Enter into discussions to support collaboration
- Review information from cataloging existing programs and determine next steps
- Complete implementation of social service data base

# Thank You



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